IN THE

Supreme Court of the United States

OCTOBER TERM 1976

No. 76-1237

RUTH FRIEDMAN, et al.,

Petitioners,

v.

STEPHEN BERGER, individually and as Commissioner of the New York State Department of Social Services, et al.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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1. Petitioners are Ruth Friedman, Raymond Franklin, Sidney Mohr, William C. Lingard, and Chaim Peimer, individually

certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit in the above-styled case, which affirmed a judgment dismissing the complaint of petitioner by the United States District Court for the Southern District of New York.

OPINIONS BELOW

The opinion of the Court of Appeals for the Second Circuit is not yet reported; it is attached hereto as Appendix A. The opinion of the District Court for the Southern District of New York is reported

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and on behalf of all other persons similarly situated.

Respondents are Stephen Berger, individually and as Commissioner of the New York State Department of Social Services, The New York State Department of Social Services, James Dumpson, individually and as Commissioner of the New York City Department of Social Services, and The New York City Department of Social Services.

at 409 F.Supp. 1225 (1976) and is attached hereto as Appendix B.

JURISDICTION

The judgment of the Court of Appeals for the Second Circuit was entered on December 8, 1976. A copy is attached hereto as Appendix C. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

QUESTION PRESENTED

The Social Security Act, 42 U.S.C. §1396a(a)(17), provides, inter alia, that a State's medical assistance program must establish standards for determining "eligibility for and amount of" medical assistance. These standards, as applied to aged, blind, and disabled persons, must "disregard" (treat as invisible) any income which would be "disregarded" in the

Supplemental Security Income program created by subchapter XVI of the Act. Subchapter XVI, 42 U.S.C. §1382a(b)(2), provides that the first $240 a year (or $20 a month) of a person's income shall be disregarded. The question presented by this petition is whether New York can, consistent with the Social Security Act, refuse to allow disabled, institutionalized recipients of medical assistance a $20 a month income disregard in calculating the amount of medical assistance they can receive?

CONSTITUTIONAL PROVISIONS, STATUTES, RULES AND REGULATIONS INVOLVED

Article VI, Clause 2 of the Constitution of the United States:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which

> shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

Social Security Act, Subchapter XVI (governing the Supplemental Security Income ["SSI"] Program), 42 U.S.C. §§1382(e)(1) and 1382a(b)(2):

§1382(e)(1):

> (A) Except as provided in subparagraph (B), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.
>
> (B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse)

under a State plan approved under subchapter XIX of this chapter, the benefit under this subchapter for such individual for such month shall be payable--

(i) at a rate not in excess of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;

(ii) at a rate not in excess of the sum of the applicable rate specified in subsection (b)(1) of this section and the rate of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home, or facility throughout such month; and

(iii) at a rate not in excess of $600 per year (reduced by the amount of any income not excluded pursuant to section 1382a (b) of this title) in the case of an individual who has an eligible spouse, if both of them are in such a hospital, home, or facility throughout such month.

§1382a(b)(2):

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded--...

(2) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the individual;...

Social Security Act, Subchapter XIX

(governing the Medical Assistance

["Medicaid"] program, 42 U.S.C. §§1396a(a)

(14)(A) and (17):

§1396a(a)(14)(A):

(a) A State plan for medical assistance must--...

(A) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate

State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)--

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1396d(a) of this title, will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan),...

§1396a(a)(17):

(a) A State plan for medical assistance must--...

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible

for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the ex-

tent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

18 New York Code of Rules and Regulations,

Section 360.5(e):

If an applicant or recipient is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for that applicant or recipient and for maintenance needs of the dependent members of his former family household. For the purpose of this subdivision and subparagraph (8) of paragraph (a) of subdivision 2 of section 366 of the Social Services Law, when a person is in chronic care, he shall not be deemed to be a member of any household except, that for the purpose of determining the amount

of the savings exemption for his former family household, he shall be considered a member thereof. All non-exempt income of such an applicant or recipient shall be utilized in the following order:

(1) to meet the maintenance needs of the dependent members of his former family household, less any amount of income in cash or in kind possessed by such dependent members in accordance with the following schedule...

(2) the balance, if any, to meet the cost of his medical assistance.

STATEMENT OF THE CASE

The great majority of people in chronic care hospitals and nursing homes are unable to pay the staggering charges of these institutions. Even people who have substantial savings when they enter an institution soon find their money exhausted. For this reason, chronic care patients in New York and many other states almost invariably become recipients of

medical assistance ("Medicaid") under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., to pay part or all of the cost of their care. The Medicaid program is jointly funded by the federal government and the State. It is administered in New York under New York Social Services Law §363 et seq. by respondent New York State Department of Social Services and local departments of social services, including respondent New York City Department of Social Services. In return for the millions of dollars a year in Medicaid money it receives from the United States, New York must operate its program in conformity with the Social Security Act ("the Act") and regulations of the United States Department of Health, Education, and Welfare ("H.E.W.").

Chronic care patients can qualify for Medicaid in two ways under the Act and New York law. Patients in the first classification are the so-called "categorically needy". These are patients who receive cash public assistance and are automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10). The cash public assistance program for needy, aged, blind, and disabled (either in or outside of chronic care institutions) is the federal Supplemental Security Income ("SSI") program, 42 U.S.C. §1381 et seq. All patients in chronic care facilities are disabled, so that criterion presents no issue here. In general, to be financially eligible for SSI a person must have income of less than $166 a month. 42 U.S.C. §1382(a)(1)(A). Because in-patients in chronic care

facilities have their housing and food expenses covered by their medical assistance benefits, however, the Act, 42 U.S.C. §1382(e)(1), establishes a separate income eligibility standard for institutionalized persons. This is $300 a year or $25 a month. 20 C.F.R. §416.231(a)(2).

Both SSI income eligibility standards are modified by the Act's requirement that, in calculating a person's eligibility, the first $240 a year or $20 a month of income must be "disregarded."* 42 U.S.C. §1382a(b)(2). "Disregarded" income is invisible for purposes of calculating eligibility for and amount of S.S.I. bene-

*The "$20 disregard" does not apply to income paid on the basis of need (that is, other welfare benefits), but none of the income of petitioners referred to herein is paid on the basis of need and therefore this limitation is not relevant to this case.

fits. Thus an institutionalized person receives cash SSI benefits if his income is less than $45 a month ($25 under the benefit standard plus $20 in disregarded income). He is not eligible for SSI benefits if his monthly income is $45 or more.

Even if a chronic care patient is not "categorically needy," he is still eligible for Medicaid if he falls into the second classification, the "medically needy." A person is "medically needy" if (1) he is eligible for SSI benefits except for his income (that is, if he is aged, blind, or disabled); and (2) he lacks sufficient income to meet his necessary medical expenses. 42 U.S.C. §1396a(a)(10)(C)(i); 45 C.F.R. §248.1(a)(2)(i). Petitioners and their class are all medically needy because they are disabled as patients

in chronic care facilities, and because they have income of more than $45 a month but less than the amount necessary to pay their high medical expenses.

To receive medical assistance, a medically needy person is required to use for medical expenses "excess" income above a specified level. This process is known as "spending down". Under a regulation of the New York State Department of Social Services, 18 N.Y.C.R.R. §360.5(e), petitioners are required to "spend down" all but $28.50 of their income to be eligible for Medicaid. 18 N.Y.C.R.R. §360.5(e) allows no disregard of $20 a month. Petitioners have available to them only the $28.50 per month for all personal expenses. Petitioners contend that the Social Security Act requires respondents to allow

them a $20 disregard in calculating the amount of money they can retain for personal expenses and thus to leave petitioners with $48.50 in available income.*

The personal expense allowance is of critical importance to petitioners, because only room, board, and medical care, are provided for by their Medicaid. Out of their personal expense allowances petitioners must pay for, among other things, clothing, shoes, shaving items, toothpaste and other toiletries, reading material, cigarettes, candy, telephone calls, transportation, and dry cleaning.

*Since New York's maintenance level is $28.50, granting plaintiffs a $20 disregard would allow them to keep $48.50 a month for personal expenses. However, New York could, consistent with federal law, lower its maintenance level to $25 and thus reduce plaintiffs' net income for personal expenses to $45. 45 C.F.R. §248.3(b)(4).

Since $28.50 a month is grossly inadequate to cover all these expenses, petitioners, some of whom, like William C. Lingard, have outside income of more than $500 a month, must do without many common necessities and small comforts of life. Like Mr. Lingard, they must make do with ancient clothing. Like Ruth Friedman and Raymond Franklin, they must forgo buying a daily newspaper because this would cost them more than one quarter of their net income. In addition, petitioners are often cut off from the outside world by their financial situation even more than by their physical condition. Mrs. Friedman cannot afford to telephone one son in Massachusetts or to visit another son in Brooklyn. Chaim Peimer cannot even travel to the Jewish Braille Institute to tape books for the

blind.

Petitioners brought this action pursuant to 42 U.S.C. §1983 challenging the failure of 18 N.Y.C.R.R. §360.5(e) to allow petitioners and their class a $20 income disregard in calculating of the amount of income they can retain for personal expenses.

By order to show cause dated January 26, 1976 petitioners moved for a preliminary injunction against defendants' enforcement of the $28.50 limitation in 18 N.Y.C.R.R. §360.5(e) on the ground that it violated the Social Security Act and H.E.W. regulations, and for an order certifying this as a class action. In a memorandum and order dated March 17, 1976, the district court dismissed the complaint

and denied petitioners' motion for class certification. Subsequently petitioners moved for reargument and reconsideration of the memorandum and order of March 17, 1976. This motion was denied by order dated April 9, 1976. Petitioners then appealed to the United States Court of Appeals for the Second Circuit, which affirmed the judgment of the District Court in an order entered December 8, 1976. This petition for certiorari was filed within 90 days thereafter.

REASONS FOR GRANTING THE WRIT

NEW YORK'S REFUSAL TO ALLOW INSTITUTIONALIZED RECIPIENTS OF MEDICAID A $20 PER MONTH INCOME DISREGARD VIOLATES THE CLEAR LANGUAGE AND POLICY OF THE SOCIAL SECURITY ACT

18 N.Y.C.R.R. §360.5(e) provides in relevant part that

"If an applicant or recipient

> [of Medicaid] is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of... $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for such applicant or recipient..."

No income disregard is provided in calculating the personal expense level and petitioners are thus left with net income of $28.50 a month.* The failure of §360.5 (e) to provide a $20 income disregard violates the clear language the Social Security Act. 42 U.S.C. §1396a(a)(17) requires, inter alia, that the state plan of a state participating in the Medicaid program

*18 N.Y.C.R.R. §360.5(e) does exempt from consideration certain property and specified income for the support of family members outside institutions. These resources are not involved in this case.

> "include reasonable standards... for determining eligibility for and the extent of medical assistance under the plan which... (B) provide for taking into account only such income and resources... (in the case of any applicant or recipient who would, except for income and resources be eligible... to have paid with respect to him supplemental security income under subchapter XVI of this chapter [)] as would not be disregarded... in determining his eligibility for such aid, assistance or benefits..." (Emphasis added).

Petitioners are persons who would "except for income and resources be eligible... to have paid with respect to [them] supplemental security income under subchapter XVI..." "Subchapter XVI", 42 U.S.C. §1382a (b)(2), provides a $20 a month income disregard. Since petitioners would be entitled to an income disregard of $20 a month in calculating their eligibility for SSI, they are also entitled to that disregard in cal-

culating their "eligibility for and the extent of medical assistance" under 42 U.S.C. §1396a(a)(17).

Despite the apparently clear language of the Act, New York contends, and the courts below have held, that the State's requirement that medically needy chronic care patients spend down to $28.50 without any disregard is legal because it has been approved by H.E.W. H.E.W. has granted its approval. H.E.W.'s Policy Information Memo No. 74-11 (March 15, 1974), a copy of which is attached hereto as Appendix D, states that "there is currently no prohibition against applying income which is disregarded in the eligibility determination toward such cost [of care], as long as the appropriate amount is retained for personal needs per CFR 248.3(b)(4) [at

least $25]." (A-33). In other words, the medically needy can be required to spend down to $25 and to forfeit the benefit of the $20 disregard.

H.E.W.'s rationale is that the statute and regulation requiring that the institutionalized medically needy be given the $20 income disregard, 42 U.S.C. §1396a (a)(17) and 45 C.F.R. §248.3(c)(3)(ii), apply only to determinations of financial <u>eligibility</u> and that, after eligibility is established, the disregard is without effect in determining, pursuant to 45 C.F.R. §§ 248.3(b)(4) and (5), the amount of net income for personal expenses which the "medically needy" can retain. See letter from Elmer Smith to John C. Gray, Jr. (Dec. 8, 1975), a copy of which is annexed hereto as Appendix E (A-37).

But H.E.W.'s position is inconsistent with both the specific provisions and the general scheme of the Social Security Act. 42 U.S.C. §1396a(a)(17) requires

> "standards for determining eligibility for and the extent of medical assistance under the plan which... provide for taking into account only such income and resources... as would not be disregarded... in determining his eligibility for such aid, assistance, or benefits." (Emphasis added).

The Act requires the application of the disregard in determining "extent of" as well as "eligibility for" medical assistance, in direct contradiction of H.E.W.'s interpretation. In the context of this case, the Act's reference to "extent of" assistance can mean nothing other than the amount of medical assistance provided. And the amount of medical assistance provided necessarily determines the amount of personal expense money left to the recipient. H.E.W.'s interpretation of the Act would make the "extent of" assistance language a nullity.

Furthermore, the separate calculations of "eligibility for" and "extent of" medical assistance are inconsistent with the entire scheme of the Social Security Act. H.E.W. admits in the Smith letter that its position on institutionalized person is

> "the only exception to the general rule of protection of disregarded income, i.e., any income which is disregarded in order to determine financial eligibility is not considered in the computing the liability for medical costs of persons who must 'spend down' to become eligible." (A-38).

Thus, the separation of the calculation of eligibility for and extent of assistance

applies only to institutionalized persons in a "spend down" situation and no other persons who "spend down": that is, a medically needy out-patient is given the benefit of the disregard. As admitted by the Smith letter, the separation appears in no other aspect of the federally-assisted welfare programs under the Social Security Act and H.E.W. regulations. In every other situation eligibility for and extent of assistance are determined by the same standard, as common sense and the Act would require that they should be.

Nothing in the Act justifies H.E.W.'s unique conclusion that the $20 disregard is effectively inapplicable to the institutionalized. On the contrary, the Act specifically provides that institutionalized S.S.I. recipients are entitled to the

$20 disregard to the same extent as non-institutionalized recipients. 42 U.S.C. §1382(e)(1)(B)(i) provides that S.S.I. benefits shall be payable to the institutionalized

> "at a rate not in excess of $300 per year (reduced by the amount of any income not excluded pursuant to Section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse."*

The "Section 1382a(b)" referred to creates the $20 disregard. Thus Congress clearly intended that the $20 income disregard of section 1382a(b) be applicable to the institutionalized.

H.E.W.'s position would again turn this express language of the Act into a nullity. All institutionalized S.S.I.

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*42 U.S.C. §§1382(e)(1)(B)(ii) and (iii) contain parallel provisions for other institutionalized persons.

recipients receive Medicaid automatically under 42 U.S.C. §1396a(a)(10). Of necessity, they must make use of Medicaid because, by definition, they have low incomes and high medical expenses. But if, to get Medicaid, the institutionalized S.S.I. recipient can be forced to spend down to a level which denies him the benefit of the $20 disregard, the provisions of 42 U.S.C. §1382(e)(1)(B) specifically allowing the institutionalized the disregard are pointless. Surely this result cannot be what Congress intended.

H.E.W.'s position also nullifies another specific provision of the Act. New York requires institutionalized recipients of cash S.S.I. benefits as well as the medically needy petitioners to spend down to $28.50. An S.S.I. recipient with

$20 income would initially have $45 available income: $20 disregarded income and $25 in benefits. 20 C.F.R. 416.231(a)(2). But the S.S.I. recipient would have to "spend down" by paying out $16.50 a month for medical expenses. This would violate 42 U.S.C. §1396a(a)(14) which provides in relevant part that a State plan for medical assistance shall

> "effective January 1, 1973 provide that -
>
> (A) in the case of individuals... with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter....
>
> (1) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of Section 1396d(a) of this title will be imposed under the plan...."

The medical services listed in clauses (1)

through (5) and (7) of section 1396d(a) include the services being provided to plaintiffs: in-patient hospital services [§1396d(a)(1)] and skilled nursing facility services [§1396a(a)(4)(A)]. The clear language of §1396a(a)(14) is, contrary to H.E.W.'s position, that the categorically needy are entitled to Medicaid at no cost to them and that they cannot be required to spend down from $45.00 to $28.50 to be eligible for medical assistance.

For the most part, the Second Circuit, below, merely defered to H.E.W.'s view of the Act. (A-14-A-15) Such deference is inappropriate where, as here, the administrative agency's interpretation is contrary to the statute. E.g., Morton v. Ruiz, 415 U.S. 199, 237 (1974); N.W.R.O. v. Mathews,

533 F.2d 637 (D.C. Cir., 1976); N.W.R.O. v. Weinberger, 377 F. Supp. 861 (D.D.C. 1974); Powell v. Austin, No. 76-0229 (E.D. Va. Dec. 3, 1976), 45 U.S.L.W. 2320. In one important respect, however, the Second Circuit went beyond and misinterpreted H.E.W.'s position. The Second Circuit reasoned that New York does, in effect, give the $20 disregard because it permits the institutionalized a personal expense allowance of $28.50, which is more than the $20 which must be disregarded (A-8); furthermore, the Act does not require that anything other than the $20 be disregarded. (A-8) This reasoning entirely misunderstands what a income disregard is. A disregard is not a minimum level of benefits in itself, but a rule used in calculating eligibility for and amount of benefits,

the level of which is set by some other standard. In this case, the personal maintenance level is set by New York State at $28.50. But New York State could not lower its level below the minimum of $25 a month set by H.E.W. regulations, 45 C.F.R. §248.3(b)(4). See H.E.W. Policy Information Memo No. 74-11 (A-33). The disregard makes invisible the recipient's first $20 in income in calculating whether the recipient has $28.50 available for personal maintenance. The Second Circuit mistakenly treated the income disregard as a benefit level, when it is intended to be an add-on to a benefit level. The Second Circuit also failed to realize that New York could not lower its personal maintenance below $25.

In contrast, H.E.W.'s position is

not that New York complies with the $20 disregard requirement in calculating the personal expense level of the institutionalized, but rather that the disregard need not be applied at all in the personal maintenance calculation because it applies only to the calculation of eligibility. H.E.W. Policy Information Memo No. 74-11 (A- 33).

In any event, the purpose of an income disregard is to allow some additional net income to a person who has non-public assistance income, in comparision to a person who has none. Unless this is done, people with some income from a private pension or from disability or retirement benefits under Title II of the Social Security Act, for which they may have worked for many years, receive no

more net benefits than the person with no such income. While New York allows a $20 difference in benefits to exist on this basis for aged, blind, and disabled people who are not in institutions, the State has virtually eliminated the difference for the institutionalized. H.E.W. and the Second Circuit would uphold New York's rule for distinct and inconsistent reasons. But the rationales of both H.E.W. and the Second Circuit violate Congress's intent, embodied in the unambiguous language of the Social Security Act, to allow the institutionalized aged, blind, and disabled the benefit of a $20 income disregard.

This violation of Congressional intent severely damages ten of thousands of disabled, institutionalized persons in New

York and in many other states. The result is the utter impoverishment and unnecessarily complete isolation of the many chronic in-patients who would like to visit briefly or telephone family or friends but cannot because of lack of funds. A violation of federal law causing severe personal deprivation to the most afflicted persons in our society should not be allowed to stand.

CONCLUSION

For all the foregoing reasons, petitioners pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit entered in this case on December 8, 1976.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 84—September Term, 1976.

(Argued October 21, 1976 Decided December 8, 1976.)

Docket No. 76-7187

RUTH FRIEDMAN, RAYMOND FRANKLIN, SIDNEY MOHR, WILLIAM C. LINGARD, and CHAIM PEIMER, individually and on behalf of all other persons similarly situated,

Plaintiffs-Appellants,

v.

STEPHEN BERGER, individually and as Commissioner of the New York State Department of Social Services; THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, JAMES DUMPSON, individually and as Commissioner of the New York City Department of Social Services; and THE NEW YORK CITY DEPARTMENT OF SOCIAL SERVICES,

Defendants-Appellees.

Before:

FRIENDLY, HAYS and MULLIGAN,
Circuit Judges.

Appeal from an order of the District Court for the Southern District of New York, Inzer B. Wyatt, *Judge*, dismissing a complaint wherein plaintiffs challenged the validity of a regulation requiring "medically needy" insti-

tutionalized recipients of Medicaid to "spend down" to $28.50 per month of their income. Affirmed.

JOHN C. GRAY, JR., Esq., Brooklyn, New York (Lloyd Constantine, Esq., and Brooklyn Legal Services Corp., of Counsel), *for Plaintiffs-Appellants.*

ROBERT S. HAMMER, Assistant Attorney General (Louis J. Lefkowitz, Attorney General of the State of New York, and Samuel A. Hirshowitz, First Assistant Attorney General, of Counsel), *for Defendants-Appellees.*

FRIENDLY, *Circuit Judge:*

This appeal raises the question how much personal income can be retained by individuals who are receiving assistance under the New York State Medicaid program[1] while in a hospital or nursing home for extended care and in particular whether a New York State Medicaid regulation restricting the amount of retained income to $28.50 per month is valid under the federal Social Security Act and pertinent regulations.

Plaintiffs are recipients of New York State Medicaid who are aged, blind, or chronically ill, have been in hospitals or nursing homes for one month or longer, and qualify as "medically needy"; this designation[2] means that their annual income is too low to meet their medical expenses

1 Medicaid, established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396g, is a medical assistance program jointly funded by the federal and state governments. Federal payments are available to states which secure HEW approval of plans for medical assistance. New York State participates in the Medicaid program pursuant to New York Social Services Law (NYSSL) §§ 363-369.

2 45 C.F.R. § 248.1(a)(2)(i); *see* NYSSL § 366(1)(a)(5).

including the enormous cost of institutional care but too high to qualify them for the federal cash grant program providing "Supplemental Security Income" (SSI) for the aged, blind, and disabled.[3] By federal law the provision of Medicaid assistance to such persons is a matter of state option, 42 U.S.C. § 1396a(a)(10)(C), but must conform to federal requirements. Aged, blind, and disabled patients whose personal incomes *are* low enough to qualify under the SSI program are considered "categorically needy"[4] and must be included within any state Medicaid plan, 42 U.S.C. § 1396(a)(10)(A).

At issue is how much personal income of "medically needy" Medicaid recipients such as plaintiffs can be required to be applied toward the cost of institutional care as a condition of their receiving Medicaid. The New York regulation under challenge is 18 New York Code of Rules and Regulations (NYCRR) § 360.5(e), which provides that a Medicaid recipient who is "receiving chronic care in a medical institution or intermediate care facility" and has no dependents can retain only $28.50 per month of his income for personal expenses. "[A]ll resources in excess . . . shall be utilized to meet the cost of medical assistance for that applicant or recipient . . . ."[5] In Social Security idiom, the

3 The SSI program, established under 42 U.S.C. §§ 1381-1383c, provides aid to aged, blind, or disabled persons whose income does not exceed $166 per month. 42 U.S.C. § 1382(a)(1)(A). If, like plaintiffs, such aged, blind, or disabled persons are confined to a hospital, nursing home or intermediate care facility for one month or longer, the income cut-off is lowered to $45 per month because of the decreased costs of their maintenance to themselves. 42 U.S.C. § 1382(e)(1)(B)(i).

4 45 C.F.R. § 248.1(a)(1)(i); *see* NYSSL § 366(1)(a)(2).

5 18 NYCRR § 360.5(e) provides in pertinent part:

> If an applicant or recipient [of Medicaid] is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be

regulation requires institutionalized Medicaid recipients such as plaintiffs to "spend down" to all but $28.50 per month of their income. Putting constitutional arguments aside, plaintiffs urge that this regulation is deficient for two reasons: first, that the Social Security Act provides medically needy Medicaid recipients with an express guarantee of at least $45 retained income per month; and second, that, even if this not be so, the Social Security Act requires that the medically needy be aided under standards "comparable" to those applied to categorically needy Medicaid recipients who are allegedly permitted to retain more than $28.50 personal income under the New York State program.

Plaintiffs are appealing here from a decision of Judge Wyatt in the District Court for the Southern District of New York, 409 F. Supp. 1225, denying their motion to certify as a class all Medicaid recipients in chronic care institutions with personal incomes in excess of $45 and a preliminary injunction against enforcement of 18 NYCRR § 360.5(e) and directing dismissal of the complaint. Jurisdiction is adequately based on 28 U.S.C. § 1343(3) because of plaintiffs' dormant constitutional claim.[6] We affirm the

utilized to meet the cost of medical assistance for that applicant or recipient . . . .

NYSSL § 366(2)(a) concerns the disregard of certain property and, for persons with legal dependents, a certain amount of income for the dependents' support. The named plaintiffs here have not specified whether they and members of their proposed class are without dependents, although such seems to be implied by their averment that they are permitted to keep only $28.50 per month. In any event, the income disregard permitted by NYSSL § 366(2)(a) is not of relevance to the question of plaintiffs' income disregard for their *own* maintenance needs.

6 Plaintiffs' complaint urged constitutional as well as statutory grounds. This was that New York enforced a more severe spend-down requirement on medically needy than on categorically needy and that this was an arbitrary classification in violation of the equal protection and due process clauses of the Fourteenth Amendment. Facially, under the liberal view taken in *Goosby* v. *Osser*, 409 U.S. 512 (1973), this raised a constitutional claim sufficiently substantial to vest the district court

dismissal of the complaint, though on somewhat different reasoning; in light of this we do not reach the question of class certification.

I.

Explanation of plaintiffs' first claim requires a foray into statutory provisions and HEW regulations of labyrinthine complexity.[7] Under Title XIX of the Social Security Act, the Medicaid legislation, a state which wishes to participate in Medicaid must submit a plan for providing such assistance that conforms with federal law. 42 U.S.C. § 1396a(a)(17) requires that:

with jurisdiction over both it and the statutory claims, see *Hagans* v. *Lavine*, 415 U.S. 528, 537-40 (1974). Jurisdiction having been thus acquired, it did not cease because further examination of the law and the facts necessary to determine the statutory claim showed that the constitutional claim was in truth insubstantial, see note 16 *infra*. The decision of a dividend panel in *Murrow* v. *Clifford*, 502 F.2d 1066 (3 Cir. 1974), that although a single judge can uphold a pendent statutory claim, he cannot deny it where the constitutional claim was both facially and factually substantial, is not to the contrary. We take no position with respect to that decision, see *Doe* v. *Beal*, 523 F.2d 611, 623-24 (3 Cir. 1975) (en banc), *certiorari granted*, No. 75-554, 44 U.S.L.W. 3757 (U.S. July 6, 1976); *Murrow* v. *Clifford*, 404 F. Supp. 999, 1001 n.4 (D.N.J. 1975); *Parks* v. *Harden*, 504 F.2d 861, 866-67 (5 Cir. 1974), *vacated on other grounds*, 421 U.S. 926 (1975); 88 Harv. L. Rev. 1028, 1030-31 (1975); 64 Geo. L.J. 113, 118-22 (1975); 85 Yale L.J. 564, 571 n.42 (1976); 66 F.R.D. 495, 510-11. Hopefully, in light of the blessed demise of 28 U.S.C. §§ 2281 and 2282 and, in largest part, § 2284 resulting from P.L. 94-381, we may never need to do so.

7 As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated. There should be no such form of reference as "45 C.F.R. § 248.3(c)(1)(ii)(B)(*2*)" discussed below; a draftsman who has gotten himself into a position requiring anything like this should make a fresh start. Such unintelligibility is doubly unfortunate in the case of a statute dealing with the rights of poor people. An indispensable service is performed by attorneys like those representing the plaintiffs here, who advance tenable claims with clarity and courtesy—even if, as in this case, not with success.

A State plan for medical assistance must—

. . .

(17) include reasonable standards . . . *for determining* eligibility for and *the extent of medical assistance under the plan* which . . . (B) provide for *taking into account only such income and resources* . . . (in the case of any applicant or recipient who would, except for income and resources, be eligible . . . to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter [the SSI program] *as would not be disregarded* (or set aside for future needs) *in determining his eligibility for such aid, assistance or benefits.* . . . (emphasis added).

In other words, for persons such as plaintiffs, who would be eligible to receive SSI benefits because of their age, blindness or disability were it not for their income, state standards must provide that income which is disregarded in determining SSI eligibility also be disregarded in dedetermining eligibility for and the extent of medical assistance under Medicaid. This statutory requirement is supplemented by HEW regulation, 45 C.F.R. § 248.3(c)(3)(ii)(A).[8]

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8 The regulation provides:

(c) With respect to the medically needy, the State plan [under Title XIX of the Social Security Act] must:

. . .

(3) Provide that all income and resources will be considered in establishing eligibility, and for the flexible application of income to medical costs not in the plan, and for payment toward the medical assistance costs. *In considering all income and resources when establishing eligibility, the State plan must provide for:*

. . .

(ii) In the case of the aged, blind, or disabled, the highest of:

(A) *The disregards applied in title XVI* . . . . (emphasis added).

Unfortunately for the plaintiffs, however, when one turns to the portion of the Social Security Act governing disregards under the SSI program, Title XVI, one discovers that only $20 per month is subject to such disregard. 42 U.S.C. § 1382(e)(1) reads as follows:

(e) Limitation on eligibility of certain individuals.

(1)(A) Except as provided in subparagraph (B), no person shall be an eligible individual . . . for purposes of this subchapter [Title XVI] with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual . . . is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual . . .) under a State plan approved under subchapter XIX [Medicaid] of this chapter, the benefit under this subchapter [XVI] for such individual for such month shall be payable—

(i) at a rate not in excess of $300 per year *(reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title)* in the case of an individual who does not have an eligible spouse; . . . . (emphasis added)

42 U.S.C. § 1382a(b) in turn provides that:

in determining the income of an individual [for purposes of Title XVI] . . . there shall be excluded—

. . .

(2)(A) The first $240 per year (or proportionately smaller amounts for shorter periods) of income

> (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual; . . . .

As these sections show, for SSI purposes only the first $240 income per year, or $20 per month is disregarded in establishing statutory eligibility for SSI payments. Any income above that amount is not disregarded, and reduces accordingly the size of the SSI payment. Though institutionalized SSI recipients also receive a $25 benefit payment each month as their aid under the SSI program, such program benefits have no relation to the "income and resources" whose "disregard" under the SSI program is used as a benchmark in § 1396a(a)(17) of the Medicaid legislation; indeed, as the language of the latter section makes clear, the very purpose of the disregard of income and resources in Title XVI is to establish the proper size of SSI benefits.

What this means, of course, is that medically needy Medicaid recipients in New York State already receive the full equivalent of the SSI eligibility disregard. The New York State regulation makes clear that no one receiving chronic care in a medical institution under the State Medicaid program shall be required to "spend down" lower than $28.50 per month, considerably above the $20 minimum mandated by §§ 1396(a)(17), 1382(e)(1) (A) and (B), and 1382a(b), and 45 C.F.R. § 248.3(c)(3)(ii)(A). Though 42 U.S.C. § 1396a(a)(17) forbids taking into account in the Medicaid program any "income and resources" which would be disregarded in SSI eligibility determinations ($20 per month), and 45 C.F.R. § 248.3(c)(3)(ii)(A) requires use of "the highest of . . . [t]he disregards applied in title XVI," neither provision forbids taking into account income equivalent to the SSI benefits themselves ($25 per month).

II.

Plaintiffs' alternative claim is that the New York State regulation violates a "comparability" requirement of the Social Security Act because it purportedly limits the retained income of "medically needy" institutionalized Medicaid recipients such as plaintiffs more stringently than it does the retained income of "categorically needy" institutionalized Medicaid recipients. This alleged discrimination is likewise the basis of plaintiffs' equal protection claim.

The comparability requirement is derived from two sources. The first is 42 U.S.C. § 1396a(a)(17):

> A State plan for medical assistance must—
>
> . . . .
>
> (17) include reasonable standards (which shall be comparable for all groups . . .) for determining eligibility for and the extent of medical assistance under the plan . . . .

Plaintiffs' theory presumably is that if more of a medically needy non-SSI recipient's income is taken under the Medicaid program, he receives pro tanto less subsidization and thus less "medical assistance" than does a categorically needy SSI recipient. The second source for a comparability requirement is 45 C.F.R. § 248.3(c)(1)(ii)(B)(*2*), requiring that for the medically needy the state plan shall provide "income levels for maintenance" equal to the "highest level of payment which is generally available to individuals in any of the three groups (aged, blind and disabled) who are . . . eligible for benefits under title XIX . . . ." *See Aitchison* v. *Berger*, 404 F. Supp. 1137, 1143-44 (S.D.N.Y. 1975) (Frankel, *J.*), *aff'd without opinion*, 538 F.2d 307 (2 Cir.), *cert. denied*, 45 U.S.L.W. 3280 (U.S. October 12, 1976); *cf. Dominguez* v. *Milliken*, CCH Medi-

care and Medicaid Guide ¶ 26,633 (W.D. Mich. 1973); *Schaak* v. *Schmidt*, 344 F. Supp. 99 (E.D. Wis. 1971).[9]

The flaw in plaintiffs' comparability argument is that there has been no showing that catgorically needy Medi-

9 45 C.F.R. § 248.3(c) provides:

> With respect to the medically needy, the State plan must:
>
> (1) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:
>
> . . .
>
> (ii) . . . the income levels for maintenance must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment program, that is:
>
> . . .
>
> (B) In the case of individuals, or families (including families with children) of two persons, at the higher of:
>
> . . .
>
> (*2*) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind and disabled) who are (or would be, except for income) eligible for benefits under title XIX;
>
> . . .
>
> (2) Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:
>
> (i) First, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance . . .
>
> (ii) Next, income will be applied to costs incurred for medical insurance premiums . . ., for any copayments or deductibles . . ., and for necessary medical or remedial care recognized under State law and not encompassed with the State plan for medical assistance. . . .
>
> (iii) All of the remaining excess income and medical resources in the form of insurance or other entitlement will be applied to costs of medical assistance included in the State plan. . . .

As Judge Frankel noted in *Aitchison* v. *Berger*, *supra*, 404 F.Supp. at 1144 n.18, strictly speaking it is subdivision (2) of § 248.3(c) which is more apposite to comparability since that subdivision concerns how much of a medically needy person's income can be used to defray the costs of medical assistance, while subdivision (1) concerns *eligibility* for Medicaid payments. However, as Judge Frankel noted, "the established level" protected by (2) would sensibly be construed as the same as the minimum eligibility requirements established by (1).

caid recipients themselves keep anything more than $28.50. The New York "spend down" regulation applies on its face to *all* institutionalized Medicaid recipients, and plaintiffs now concede (plaintiffs' brief at 11 n.), on the basis of affidavits submitted by the defendants,[10] that the categorically needy like the medically needy are in practice normally prevented from keeping more than that amount.

Plaintiffs thus are forced to argue that the enforcement of the $28.50 spend-down against categorically needy SSI recipients is itself in conflict with federal law. Though we do not agree with the district court's conclusion that, in so contending, plaintiffs are relying on the rights of third parties which they lack standing to assert, there is no support in the Social Security Act or pertinent regulations for any prohibition against the $28.50 spend-down for the categorically needy.

The Title XVI provisions, 42 U.S.C. § 1382(e)(1)(B)(i) and § 1382a(b)(2)(A), quoted above, provide that institutionalized persons receiving Medicaid are eligible for SSI payments at a rate "not in excess of" $25 per month, to be reduced by any personal income exceeding $20 per month, thus allowing an institutionalized SSI recipient to attain a monthly income up to $45 before he becomes ineligible for SSI aid. But there is nothing in Title XVI that forbids the use of the $20 income disregard toward the costs of medical assistance under the Medicaid program. Furthermore, Medicaid recapture of the SSI income disregard makes some sense as a way of benefiting

10 See Affidavit of J. Raymond Diehl, Jr., Associate Commissioner, Bureau of Operations, Division of Medical Assistance, New York State Department of Social Services (April 2, 1976) (plaintiffs' appendix at R44), stating that the Department of Social Services has advised local districts that categorically needy persons are subject to the $28.50 spend-down and that a spot check of several districts showed they were requiring patients in chronic care facilities receiving SSI benefits to use income in excess of $28.50 toward the cost of medical care.

the states: the basic $25 payment under the SSI program is provided entirely by federal funding, 42 U.S.C. § 1381a, while in the Medicaid program from 17 to 50 per cent of funding must be provided by the participating state, 42 U.S.C. §§ 1396b(a), 1396d(b). The recapture of the income disregard for the costs of medical assistance is therefore not merely a matter of transferring monies from one federal coat pocket to another.

Plaintiffs instead propose that 42 U.S.C. § 1396a(a)(14) invalidates New York's requirement that categorically needy Medicaid recipients spend down to $28.50. Section 1396a(a)(14)(A) states that:

> A State plan for medical assistance must—
>
> . . .
>
> (14) effective January 1, 1973, provide that—
>
> (A) in the case of individuals . . . with respect to whom supplemental security income [SSI] benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of . . . the supplemental security income program under subchapter XVI of this chapter, . . .
>
> (i) no enrollment fee, premium, or similar charge, and *no deduction, cost sharing, or similar charge* with respect to the care and services listed in [42 U.S.C. § 1396d(a)(1)-(5), (7)][11] will be imposed under the plan, and
>
> (ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and

11 These categories include inpatient and outpatient hospital services, other laboratory services, physicians' services, and skilled nursing facility services.

> services[12] will be nominal in amount . . . .[13] (emphasis added)

Despite plaintiffs' contention, we find no evidence that Congress intended by this to prohibit the spend-down of disregarded income to cover the cost of institutionalized care. The purpose of the cost-sharing prohibition was to make sure that the states did not reduce individuals' income below the level "necessary for maintenance."[14]

12 These include prescribed drugs, dental services, and physical therapy, 42 U.S.C. § 1396d(a)(6), (8)-(17).

13 Plaintiffs' use of this section as the basis for a comparability argument is somewhat roundabout, since § 1396(a)(14)(B) provides directly that for medically needy individuals, who are not receiving SSI assistance, "any deductible, cost-sharing, or similar charge imposed under the plan will be nominal."

14 *See* Senate Report No. 404, 89th Cong., 1st Sess. (1965):

> The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to . . . [the provision] described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligilibity under the State plan. Such action would reduce the individual below *the level determined by the State as necessary for his maintenance.*
>
> . . .
>
> No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect to require the individual to use his income or resources (*except such income as exceeds the State's maintenance level*) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan. (emphasis added).

Reprinted in U.S. Code Cong. & Admin. News 2019 (1965).

That Congress considered the $25 basic SSI cash payment at least minimally adequate for the personal needs of institutionalized persons is apparent from the very fact that this is the only amount available to the most needy persons who are lacking any outside income.[15] This is the view adopted by HEW, see HEW Policy Information Memo No. 74-11 (March 15, 1974):

> Regarding the relationship between application of an institutionalized categorically needy individual's income toward his medical costs, and prohibitions against cost sharing prior to enactment of P.L. 92-603, the statutory limitations on cost sharing charges which may be imposed on the categorically needy were designed to assure that the State-established maintenance standard necessary to meet expenses of daily living was protected for such individuals. In establishing a lower maintenance level applicable to institutionalized individuals, for whom most of such expenses are met by the title XIX vendor payment, application of an institutionalized individual's income above the lower maintenance level toward the cost of care in the facility is not in conflict with the purpose or intent of limitations on cost-sharing.

This reasonable view of the statute by an agency entrusted with its execution is "entitled to considerable deference,"

15 *See* House Report No. 231, 92 Cong., 2d Sess. (1971), which accompanied the general revision of Title XVI:

> People who are residents of certain public institutions, or hospitals or nursing homes which are getting Medicaid funds, would get benefits of up to $25 a month (reduced by non-excluded income). For these people most subsistence needs are met by the institution and full benefits are not needed. Some payment to these people, though, would be needed to enable them to purchase small comfort items not supplied by the institution.

Reprinted in U.S. Code Cong. & Admin. News 5136 (1972).

McGraw v. *Berger*, 537 F.2d 719, 725 (2 Cir. 1976); *New York Department of Social Services* v. *Dublino*, 413 U.S. 405, 421 (1973), and nothing has been cited to us in the language or legislative history of the Social Security Act that is inconsistent with HEW's view.

The only apparent limit on spend-down for the categorically needy lies in 45 C.F.R. § 248.3(b)(4)(i). (The limit is one that in fact covers the medically needy as well, thus rendering redundant any comparability argument.) This HEW regulation provides:

> (b) With respect to both the categorically needy and, if they are included in the plan, the medically needy, a State plan [under Title XIX] must:
>
> . . .
>
> (4) Provide that a lower income level for maintenance shall be used for individuals not living in their own homes but receiving care in hospitals, skilled nursing facilities, intermediate care facilities, and institutions for tuberculosis or mental diseases which are covered under title XIX. This lower income level must be reasonable in amount for clothing and personal needs for such individuals, and
>
> (i) For aged, blind, and disabled individuals, such income level must be at a minimum of $25.00 per month; . . . .

Thus a state spend-down requirement could not lower a Medicaid recipient's retained income and SSI payments below $25.00. But New York's $28.50 spend-down requirement is of course in full compliance with that minimum.

This view of the statute and the legality of a $28.50 spend-down requirement is supported by HEW's own interpretation. *See* HEW Policy Information Memo No. 74-11:

> In determining financial eligibility for Medicaid, in addition to other disregards, the amount of the Supplemental Security Income (SSI) benefit and any State supplementary payment must be disregarded in computing income of the individual. In computing income available for application toward the cost of care in the facility, there is currently no prohibition against applying income which is disregarded in the eligibility determination toward such cost, as long as the appropriate amount is retained for personal needs, per 45 CFR 248.3(b)(4).

See also Letter from HEW Regional Commissioner Elmer W. Smith to John Gray, December 8, 1975 (plaintiffs' appendix at R23):

> The fact that $20 of his income was not counted in determining his financial eligibility for SSI benefits (and in most States his financial eligibility for Medicaid), does not require that such amount also be protected in determining how much income is to be applied to medical costs. Therefore, in computing income available for application toward the cost of care in the facility, there is currently no prohibition against applying income which was disregarded in the eligibility determination toward such cost, as long as the appropriate amount is retained for personal needs, per 45 CFR 248.3(b)(4).

We see no reason to differ with HEW's interpretation.

It is understandable that plaintiffs and their able counsel should regard $28.50 a month as a sum unduly low to meet the personal needs of institutionalized Medicaid recipients, especially of the "medically needy," many of whom have been accustomed to better things. While some

of the instances cited are indeed pathetic, we must not forget—more important we think Congress did not forget—the vast amount of public money expended to furnish plaintiffs with institutional care. Congress therefore has seen fit to protect only a modest portion of recipients' income against recapture and to allow the rest to be used to meet their medical costs. In requiring a spend-down to $28.50 per month, New York has not transgressed any federal command.

The judgment dismissing the complaint is affirmed.[16] No costs.

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16 Submission of uncontroverted proof that New York is not in fact discriminating with respect to Medicaid against the medically needy in favor of the categorically needy, see note 10 *supra*, and the district court's correct overruling of plaintiffs' claim that the Social Security Act required such discrimination, both done in the course of exercising its power to examine the statutory claim, deprived plaintiffs' constitutional claim, which facially passed the substantiality test, see note 6 *supra*, of the substantiality required to trigger a request for convoking a three-judge court.

APPENDIX B

Ruth FRIEDMAN et al.,

v.

Stephen BERGER, Individually and as Commissioner of the New York State Department of Social Services, et al., Defendants.

No. 75 Civ. 6485.

United States District Court,
S. D. New York.

March 17, 1976.

"Medically needy" persons under medicaid statute brought action challenging New York's administration of the statute. The District Court, Wyatt, J., held that under New York law, neither "categorically needy," nor "medically needy" persons under chronic care were entitled to obtain more than $28.50 per month for personal expenses, and the "medically needy" plaintiffs had no standing to complain even if New York officials were in fact allowing "categorically needy" persons under chronic care to retain $45 per month for personal expenses.

Dismissed.

1. Federal Civil Procedure ⇐181

Where proposed class of medicaid recipients, which was determined by income level, would have no legal meaning or significance, motion for class action determination would be denied. Fed. Rules Civ.Proc. rule 23(c)(1), 28 U.S.C.A.

2. Social Security and Public Welfare ⇐241

Under New York medicaid statute, neither "categorically needy", nor "medically needy" persons under chronic care were entitled to retain more than $28.50 per month for personal expenses, and even if New York officials were in fact allowing "categorically needy" persons under chronic care to retain $45 per month for personal expenses, "medically needy" persons who were allegedly allowed to retain only $28.50 per month had no standing to complain. Social Security Act, §§ 1601–1634, 1611(a)(1), 1902(a)(10), (10)(A), 42 U.S.C.A. §§ 1381–1383c, 1382(a)(1), 1396a(a)(10), (10)(A); Social Services Law N.Y. § 366, subd. 1(a)(2, 5).

John C. Gray, Jr., Brooklyn Legal Services Corp. B, Brooklyn, N.Y., for plaintiffs; John M. Fredenburg, Los Angeles, Cal., National Health Law Program, of counsel.

Louis J. Lefkowitz, Atty. Gen., New York City, for defendants Stephen Berger and New York State Dept. of Soc. Serv.; Robert S. Hammer, Asst. Atty. Gen., New York City, of counsel.

WYATT, District Judge.

This is a motion by plaintiffs for an order (a) "certifying" (determining) that this action may be maintained as a class action (Fed.R.Civ.P. 23(c)(1)) and (b) granting a preliminary injunction restraining the alleged unlawful enforcement of Section 360.5(e) of Title 18 of the official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR).

1.

In 1965, Congress added a new Title XIX to the Social Security Act (42 U.S.C. § 1396 and following). This was entitled "Grants to States for Medical Assistance Programs" and apparently has come to be called "Medicaid".

The 1965 addition provided for payments by the federal government to states which submit and secure approval by HEW of state plans for medical assistance. New York is such a state.

The Medicaid statute provides through the states for "medical assistance on behalf of . . . aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . ." (42 U.S.C. § 1396).

The Medicaid statute (as is true of other parts of the Social Security Act) is an aggravated assault on the English language, resistant to attempts to understand it. The statute is complicated and murky, not only difficult to administer and to interpret but a poor example to those who would like to use plain and simple expressions. The present motion must be decided, however, and what follows is the result of best efforts to find the meaning of the Medicaid statute and other relevant statutes and regulations.

2.

The case at bar deals with two groups eligible for Medicaid assistance, the "categorically needy" and the "medically needy". The quoted terms come from federal regulations cited hereafter.

The eligibility of the two groups is based on provisions of the Medicaid statute (42 U.S.C. § 1396a(a)(10) and (17)) and the related New York statute (Social Services Law § 366(1)(a)(2) and (5)).

3.

By federal law, the state plans for medical assistance *must* provide "for making medical assistance available to all individuals . . . with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter" (42 U.S.C. § 1396a(a)(10)(B)).

"[S]ubchapter XVI of this chapter" provides for "Supplemental Security Income for Aged, Blind and Disabled" (42 U.S.C. §§ 1381–1383c). Eligible individuals are those aged, blind, or disabled whose income does not exceed $1752 per year (42 U.S.C. § 1382(a)(1)). Money benefits are payable; these are usually called Supplemental Security Income benefits or "SSI benefits".

Federal regulations describe those who are "categorically needy" in relevant part as follows (45 CFR § 248.1(a)(1)(i)):

> "In order to be considered as categorically needy [for purposes of the Medicaid statute] an individual must in general be receiving financial assistance or sufficiently in need to be financially eligible for financial assistance under title . . . XVI of the Social Security Act . . .".

The New York plan for medical assistance is provided for in Title 11 of Article 5 of the Social Services Law ("SSL") (§§ 363–369).

SSL § 366(1)(a)(2) provides for medical assistance to persons who are "receiving or . . . eligible to receive federal supplemental security income payments . . . ." This seems to cover the "categorically needy".

4.

By federal law, the state plans for medical assistance *may* provide "for

making medical assistance available to all individuals who would, except for income and resources, be eligible . . . to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient . . . income and resources to meet the costs of necessary medical and remedial care and services . . . " (42 U.S.C. § 1396a(a)(10)(C)(i)).

The reference to "subchapter XVI" etc. is to SSI benefits already explained.

Federal regulations describe those who are "medically needy" as follows (45 CFR § 248.1(a)(2)(i)):

> "An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care and services."

The New York plan provides for medical assistance to the medically needy but does not describe them exactly as does the quoted federal regulation. SSL § 366(1)(a)(5) provides for medical assistance to a person who

> ". . . although not receiving nor in need of public assistance or care for his maintenance under other provisions of this chapter, has not, according to the criteria and standards established by this article or by action of the department, sufficient income and resources, including available support from responsible relatives, to meet all the costs of medical care and services available under this title, and is either (i) under the age of twenty-one years or over the age of sixty-four years or (ii) a spouse of a cash public assistance recipient living with him and essential

> or necessary to his welfare and whose needs are taken into account in determining the amount of his cash payment or (iii) for reasons other than income or resources, is eligible for aid to dependent children or federal supplemental security income benefits and/or additional state payments; . . . ."

This seems to cover in substance the "medically needy".

5.

If a person receiving SSI benefits is in a hospital, skilled nursing facility or intermediate care facility receiving Medicaid assistance the SSI benefits are $300 per year or $25 per month (42 U.S.C. § 1382(e)(1)(B); 20 CFR § 416.231(a)(2)). In determining eligibility for SSI benefits (income of no more than $1752 per year), the first $240 per year of income (or $20 per month) is excluded. 42 U.S.C. § 1382a(b)(2) The combined effect of the cited statutes and regulation—according to the plaintiffs—is that a "categorically needy" individual (one receiving SSI benefits) who is in a hospital or other institution in New York and receiving Medicaid assistance and who has income of at least $20 per month, is able to retain $45 per month for personal needs. This is not true, as will be seen. If any such individuals are in fact retaining $45 per month for personal needs, it is not because of the cited statutes and regulation (or any others).

The question may be asked at this point: if a "categorically needy" person in an institution for chronic care has income of more than the sum retained for personal needs but less than $1752 per year (the maximum income beyond which a person is ineligible for SSI benefits, 42 U.S.C. § 1382(a)(1)), what happens to the difference?

Counsel have not supplied any answer to this question and have cited nothing from the Medicaid statute on the point.

The federal regulations require that the state plan must provide that individuals in "long term care facilities" apply their income "first to personal needs" and then "for the application of the remainder to the cost of medical or remedial care". 45 CFR § 248.3(b)(5).

Counsel have not cited anything in SSL which deals with the matter and a study of its provisions discloses nothing which seems to be relevant.

The state regulations, however, include a provision, that which is attacked in this action, which provides that all resources of Medicaid recipients in excess of $28.50 per month (with irrelevant exceptions) must be used to meet the cost of their medical assistance (that is, must be turned over to the state or to the medical institution). This provision is in 18 NYCRR § 360.5(e) and in relevant part reads as follows:

> "If an applicant or recipient is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for that applicant or recipient and for maintenance needs of the dependent members of his former family household."

This seems to mean that as to the "chronically needy" all income above $28.50 per month (and of course below $1752 per year because no "categorically needy" person could have more than that) "shall be utilized to meet the cost

of medical assistance . . . ." etc. It seems equally to mean that as to the "medically needy" all income above $28.50 per month "shall be utilized to meet the cost of medical assistance . . . ." etc.

In calculating the excess of $28.50, there are the exemptions specified in SSL § 866(2)(a). These include income of $2700 for a single person and increasing income amounts if there are more "family members". However, according to the regulation—18 NYCRR § 360.5(e)—a Medicaid recipient "receiving chronic care in a medical institution" does not count as one of the "family members" and thus a single person would not have any income exemption, a person with one family member would have a $2700 income exemption, and upwards from that amount for additional family members.

It appears, therefore, that according to the state regulation, a single person receiving chronic care in a medical institution would be able to keep "for personal expenses" $28.50 per month, whether "categorically needy" or "medically needy" and a person having one or more family members and who is receiving chronic care in a medical institution would be able to keep $28.50 "for personal expenses" per month plus upwards of $2700 as an income exemption.

6.

[1] The complaint (para 2) describes plaintiffs as all having income "of over $45 a month" and this is repeated later is describing the class (para 7).

What legal significance the $45 figure has, does not appear.

It may be that plaintiffs have the mistaken notion that a person having more

than $45 per month income is ineligible to receive SSI benefits. The following statement appears in the memorandum of law for plaintiffs (p. 1), referring to the composition of the claimed class: "They all have income of more than $45 a month and, because of this, are not eligible for cash public assistance under the Supplementary Security Income ("SSI") program, 42 U.S.C. § 1381 *et seq.*, which would otherwise be available to them as disabled persons." This seems to be an error. Reference to the cited statute shows that the eligibility test for SSI benefits is whether a person has income of more than $1752 per year, or $146 per month. 42 U.S.C. § 1382(a)(1).

A class composed of persons having income "of more than $45 a month", as claimed here (complaint para 7), would appear to have no legal meaning or significance.

The motion for class action determination is for this reason (and there are other reasons) denied.

7.

[2] The present action seems to assert some claim, never put in plain words, that plaintiffs and their class are "medically needy" and are allowed by New York to retain only $28.50 per month "for personal expenses" whereas those who are similarly situated but are "categorically needy" are allowed by New York to retain $45 per month "for personal expenses". It is not easy to deduce this from the complaint but it seems to be so.

According to my understanding of the admittedly difficult statutes and regulations, the claim has not the slightest basis and is frivolous. If in fact the administration of Medicaid in New York is

producing the result claimed by plaintiffs, the remedy should be a reduction of all Medicaid recipients—whether "categorically needy" or "medically needy"—to an allowance of $28.50 per month. It would be absurd to increase the allowance to plaintiffs to $45 which, if presently permitted to the "categorically needy", seems indefensible.

8.

The complaint attempts to state five separate claims but they all seem to be but variations on a basic grievance.

The basic grievance seems to be that plaintiffs are "medically needy", that they are receiving chronic care in an institution, that under 18 NYCRR § 360.-5(e) they can retain from their income "for personal expenses" $28.50 per month, and that "categorically needy" persons receiving chronic care in an institution can retain from their income "for personal expenses" $45 per month.

It will be assumed for present purposes that plaintiffs are "medically needy" but it is obvious from the complaint that a number of plaintiffs are "categorically needy" and are eligible for SSI benefits because they have income of less than $146 per month.

Plaintiffs never explain how the "categorically needy" manage to retain from their income $45 per month "for personal expenses". It is evident that plaintiffs arrive at this figure simply by adding the $25 per month SSI benefits and the $20 per month of income disregarded in determining eligibility for SSI benefits.

There is nothing in the state regulation, 18 NYCRR § 360.5(e), which allows of such a result. The state regulation applies to *any* "applicant or recipient", whether "categorically needy" or "medically needy." All must utilize their in-

come in excess of $28.50 per month to meet the cost of medical assistance. If a "categorically needy" person is in an institution for chronic care and receives $45 per month income (SSI benefits and other income) everything above $28.50 must be used to meet the cost of medical assistance. Such is the command of the state regulation and this is entirely consistent with federal regulations. Counsel for plaintiffs commendably calls my attention to the fact that the HEW Regional Commissioner is in agreement with the view just expressed. In a letter dated December 8, 1975, the Commissioner stated:

> "The fact that $20 of his income was not counted in determining his financial eligibility for SSI benefits (and in most States his financial eligibility for Medicaid), does not require that such amount also be protected in determining how much income is to be applied to medical costs. Therefore, in computing income available for application toward the cost of care in the facility, there is currently no prohibition against applying income which was disregarded in the eligibility determination toward such cost, as long as the appropriate amount is retained for personal needs, per 45 CFR 248.-3(b)(4)."

It may be that New York officials are not in fact requiring that "categorically needy" persons under chronic care utilize their income in excess of $28.50 to meet medical costs. The complaint does not so aver. It may be that, on one mistaken theory or another, New York officials are in fact allowing "categorically needy" persons under chronic care to retain $45 per month "for personal expenses". The complaint does not so aver.

In any event, it is clear that plaintiffs are not entitled to retain more than $28.50 per month "for personal expenses". That others, wrongfully and in violation of the state regulation, are permitted to retain more is of no concern in law to plaintiffs.

The motion for a preliminary injunction is in all respects denied.

This action should not proceed further. It is without merit. While it does serve to call attention to a possible failure in some instances to enforce the state regulation, plaintiffs have no standing to complain in this respect. They have suffered no harm. No rights of theirs have been violated. There is no justiciable controversy here; there is no "concrete injury" which presents a "factual context" to enable a court to make decisions. *Schlesinger v. Reservists, etc.*, 418 U.S. 208, 221, 94 S.Ct. 2925, 2932, 41 L.Ed.2d 706, 718–719 (1974). Accordingly, the complaint is dismissed.

SO ORDERED.

APPENDIX C

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the eighth day of December one thousand nine hundred and seventy-six.

Present: HON. HENRY J. FRIENDLY

HON. PAUL R. HAYS

HON. WILLIAM H. MULLIGAN

Circuit Judges,

Ruth Friedman, Raymond Franklin, Sidney Mohr, William C. Lingard & Chiam Peimer, individually and on behalf of all other persons similarly situated,

Plaintiffs-Appellants,

v.

Stephen Berger, individually and as Commissioner of the New York State Department of Social Services, The New York State Department of Social Services,

James Dumpson, individually and as Commissioner of the New York City Department of Social Services and The New York City Department of Social Services,

Defendants-Appellees.

Appeal from the United States Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged, and decreed that the orders and judgment of said District Court be and they hereby are affirmed without costs in accordance with the opinion of this Court.

A. DANIEL FUSARO
Clerk

by /s/ Vincent A. Carlin
Vincent A. Carlin
Chief Deputy Clerk

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT
FILED

* *

DEC 8 1976

A. DANIEL FUSARO, CLERK

APPENDIX D

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

MEDICAL SERVICES
ADMINISTRATION

March 15, 1974

Our Reference - SRS-MSA-OPPE

POLICY INFORMATION MEMO No. 74-11

FOR MSA ASSOCIATE REGIONAL COMMISSIONERS

SUBJECT: Institutionalized Title XIX Patients - Personal Needs Allowance and Application of Excess Income to Cost of Care

Several inquiries have been received regarding application of two different maintenance levels to an individual in one month: the basic non-institutional maintenance level and the institutional maintenance level of $25/month. For institutionalized individuals, two separate determinations are involved: determination of financial eligibility (in most States, based on the financial eligibility standard applied to non-institutionalized individuals), and computation of available income to be applied to the cost of care in the facility.

In determining financial eligibility for Medicaid, in addition to other disregards, the amount of the Supplemental Security Income (SSI) benefit and any State supplementary payment must be disregarded in computing income of the individual. In computing income available for application toward the cost of care in the facility, there is currently no prohibition against applying income which is disregarded in the eligibility determination toward such cost, as long as the appropriate amount is retained for personal needs, per 45 CFR 248.3(b)(4).

However, in determining the amount of income to be protected for personal needs of an institutionalized individual, the fact that during both the first month and final month of institutionalization where a patient is not institutionalized "throughout the month", the patient will have out-of-institution expenses, cannot be ignored. In fact the likelihood that a person entering an institution at some point during the middle of the month will have already expended his personal income for on-going expenses is great. In such instances where institutionalization occurs only during a portion of the month, State policies must provide for an appropriate allocation of the individual's personal income for personal needs including out-of-institution expenses and, per 45 CFR 248.3 (b)(5), medical or remedial care in the institution. Note that the entire amount of the individual's personal imcome may

not necessarily be needed for out-of-institution expenses during these months of partial institutionalization. After allocation of an appropriate amount of income available to meet out-of institution expenses, and the amount protected for personal needs in the institution, any remaining income (including the SSI amount received by the individual before the institution) may be considered available for application toward medical or remedial care in the institution.

The same procedure applies at the end of the institutional stay where the individual is not institutionalized throughout the month, and he receives a full SSI payment. A problem may arise with respect to the final month if the institution has been reimbursed by title XIX before the individual receives his increased SSI benefit due because he was not institutionalized throughout the month. Such cases may be treated as an overpayment of Medicaid benefits on behalf of the individual; i.e., the State may attempt to recoup all or a portion of the overpayment from excess income available to the individual after he is released from the institution. Again, he must be allowed to retain an amount sufficient to meet his personal needs--both in and out of the institution--for that month.

It should be noted that whatever policies the State sets for allocation of income between institutional care and out-of-

institution expenses, it must also recognize an appropriate maintenance level for dependents of the institutionalized individual. In addition, 45 CFR 248.3(b)(4) provides that the State may establish a higher maintenance amount for an institutionalized individual with no spouse or dependents, to protect his household for a temporary period, not to exceed six months, if he is expected to return to his home.

With respect to concerns that application of an individual's personal income to the cost of care in the facility would be in conflict with 45 CFR 249.10(a)(6), we should note that this regulation requires that the range of medical services and benefits be available equally to all categorically eligible persons, i.e., the State could not, for example, limit the number of hospital days or long-term care benefits for one group of such individuals and not another. It sets no requirement on what portion of income may or must be applied toward the cost of care.

Regarding the relationship between application of an institutionalized categorically needy individual's income toward his medical costs, and prohibitions against cost sharing prior to enactment of P.L. 92-603, the statutory limitations on cost sharing charges which may be imposed on the categorically needy were designed to assure that the State-established maintenance standard necessary to meet expenses of

daily living was protected for such individuals. In establishing a lower maintenance level applicable to institutionalized individuals, for whom most of such expenses are met by the title XIX vendor payment, application of an institutionalized individual's income above the lower maintenance level toward the cost of care in the facility is not in conflict with the purpose of intent of limitations on cost-sharing. Section 208 of P.L. 92-603 allowed State title XIX programs to impose nominal co-payment, deductible or co-insurance charges on the categorically needy, for optional services under the plan. Where such charges are imposed, the categorically needy individual might incur cost-sharing liabilities which would reduce his available income below the amount which would otherwise have been protected for his maintenance needs.

/s/ Albert J. Richter
Albert J. Richter
Associate Commissioner
(Policy)

Source: Memorandum, H.Newman to S. Guida, Region X, 3/6/74, cleared by Office of General Counsel

APPENDIX E

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

SOCIAL AND REHABILITATION SERVICE

8 Dec. 1975

Mr. John C. Gray, Jr.
Brooklyn Legal
Services Corp. B
South Brooklyn Branch
CAP Projects
152 Court Street
Brooklyn, New York 11201

Dear Mr. Gray:

Thank you for calling our attention to what you believe may be a violation of federal law in the administration of the New York State Medical Assistance Program. Your letter calls attention to those institutionalized individual who are medically needy and who are categorically related to Aged Blind and Disabled persons.

We are in agreement that all disregards applicable to the financially needy Title XIX institutionalized individuals, must be applied in determining eligibility of the institutionalized Medically needy who are categorically related. An individual be-

comes financially eligible when his incurred medical expenses equal the amount of his net income (after disregards) above the personal needs amount; but once the financial eligibility is established, any available income (including the amount disregarded in the eligibility determination) above the amount protected for personal needs is applied toward medical care costs. (See 45 CFR 248.3(b)(5). The fact that $20 of his income was not counted in determining his financial eligibility for SSI benefits (and in most States his financial eligibility for Medicaid), does not require that such amount also be protected in determining how much income is to be applied to medical costs. Therefore, in computing income available for application toward the cost of care in the facility, there is currently no prohibition against applying income which was disregarded in the eligibility determination toward such cost, as long as the appropriate amount is retained for personal needs, per 45 CFR 248.3(b)(4).

According to our policy guides, this is the only exception to the general rule of protection of disregarded income, i.e., any income which is disregarded in order to determine financial eligibility is not considered in computing the liability for medical costs of persons who must "spend down" to becomes eligible. For institutionalized persons only, when eligibility has been established, disregarded income is then included in determining the amount of available income which is to be applied

toward the costs of medical care.

Please feel free to contact this office if you should have any further questions.

Sincerely yours,

/s/ Elmer W. Smith
Elmer W. Smith
Regional Commissioner

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1976

76-1237

RUTH FRIEDMAN, et al.,

Petitioners,

-against-

STEPHEN BERGER, individually and as Commissioner of the New York State Department of Social Services, et al.,

Respondents.

BRIEF FOR RESPONDENT IN OPPOSITION TO CERTIORARI

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IN THE

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BRIEF FOR RESPONDENT IN OPPOSITION TO CERTIORARI

Opinions Below

The opinion of the Court of Appeals for the Second Circuit is reported at 547 F. 2d 724 and is reproduced as Appendix A to the petition. The opinion of the District Court for the Southern District of New York is reported at 409 F. Supp. 1225 and is reproduced as Appendix B to the petition.

Jurisdiction

The judgment of the Court of Appeals for the Second Circuit was entered on December 8, 1976. Petitioners invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1).

Question Presented

Whether a State regulation requiring institutionalized "medically needy" recipients of Medicaid to apply all but twenty-eight dollars and fifty cents of their monthly income to their care and treatment violates the Federal Social Security Act and regulations promulgated thereunder?

Regulation Construed

18 N.Y. Codes, Rules and Regulations § 360.5(e) [Social Services] provides in pertinent part:

> "If an applicant or recipient [of Medicaid] is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for such applicant or recipient* * *".

Statement of the Case

Petitioners are in-patients in institutions for chronic conditions who are receiving "Medicaid", 42 U.S.C. § 1396, et seq., but because of their incomes, are otherwise ineligible for Supplemental Security Income (SSI) or other cash public assistance (A2-3).*

* Numbers in parentheses preceded by "A" refers to pages in the appendix to the petition.

Suing under the Civil Rights Laws, 28 U.S.C. § 1343(3); 42 U.S.C. § 1983, petitioners sought declaratory and injunctive relief against enforcement of 18 NYCRR § 360.5(e) on the grounds that it denied to them due process and equal protection of the laws under the Fourteenth Amendment to the Federal Constitution and is otherwise in conflict with the pertinent provisions of the Social Security Act and Regulations. Petitioners claimed that they are required to "spend down" to all but $28.50 per month of their income whereas recipients of SSI receive the use of an additional $20.00 per month. Plaintiffs also sought to prosecute their claims as a class action (A3-4).

In accordance with the rule against unnecessary determination of constitutional issues, Hagans v. Lavine, 415 U.S. 520, 536, 543-544 (1974); Peters v. Hobby, 349 U.S. 331, 338 (1955), the District Court first addressed itself

to the issue of whether 18 NYCRR § 360.5(e) conflicted with federal law or regulation. Having found no such conflict, the District Court dismissed the action (A27-28). Class action treatment was denied on the ground that the proposed class of "Medicaid recipients having incomes of in excess of $45 per month" lacked legal meaning (A25-26). Petitioners' motion for reargument was also denied, pet. p. 21.

The Court of Appeals affirmed (A5). It found that income "disregarded" in determining eligibility for SSI was also disregarded in determining eligibility for Medicaid (A6-8) and further, that there was no violation of the "comparability" rule, 42 U.S.C. § 1396a(a)(17); 45 C.F.R. § 248.3(c)(1)(ii)(B)(2), since "categorically needy" recipients of SSI and Medicaid were required to spend down to the same degree as petitioners (A9-11). The Court found that the spend down requirement did not violate the prohibition against cost sharing or other changes

42 U.S.C. § 1396a(a)(14)(A), (A12). That the Court found that the regulation at bar did not conflict with the congressional intent of assuming that the Medicaid benefits would not go below the amount needed for maintenance (A13). The Court observe that its interpretation of the statute was in accord with that of the Department of Health Education and Welfare as expressed in HEW Policy Information Memo No. 74-11 (March 15, 1974), (A14) and in a letter to petitioners' counsel (A16).

REASONS FOR DENYING THE WRIT

Petitioners have failed to raise any question of general importance warranting the exercise of this Court's certiorari jurisdiction, S. Ct. Rules, Rule 19(1)(b).

As far as the record shows, the regulation at bar is peculiar to the State of New York; bearing no resemblance to any statute or regulation in any other jurisdiction.

Neither is there any question that this case is governed by the "Supremacy Clause", U.S. Const., Art. VI, clause 2; or that courts will defer to the interpretation given to a statute or regulation by the agency responsible for its enforcement provided it is not contrary to the intent of Congress, Morton v. Ruiz, 415 U.S. 199, 237 (1974); Dublino v. N.Y. State Dept. of Social Services, 413 U.S. 405, 421 (1973); Udall v. Tallman, 380 U.S. 1, 16 (1964); pet. p. 32.

What remains is a question of statutory construction of purely local interest.

The analysis of the statutes and regulations by the Court of Appeals, conforms both to the intent of Congress (A13) and the interpretation of the Department of Health Education and Welfare which must administer them (A14-16). Petitioners' theory of the action, albeit imaginative, is unsupported by any other authority.

Nevertheless, even if the question sought by petitioners to be reviewed is fairly debatable or of academic interest, petitioners have failed to show that it is of sufficient general importance, Rice v. Sionx City Cemetary, 349 U.S. 70, 74 (1955) or the subject of conflicting decisions, United States v. Muniz, 374 U.S. 150, 151 (1963) as to justify a grant of certiorari.

CONCLUSION

CERTIORARI SHOULD BE DENIED

Dated: New York, New York
April 20, 1977

Respectfully submitted,

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